

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION

LICENSE APPLICATION/RENEWAL REQUEST
FOR COMMUNITY HOMES FOR PERSONS WITH DEVELOPMENTAL OR PHYSICAL DISABILITIES

Name of Corporation

Name of Community Home

Corporation Mailing Address

Community Home Address

City State Zip Code

City State Zip Code

Corporation Telephone

Community Home Telephone

Executive Director

Community Home Manager

License Application for (check one):

() Community Home for Persons with Developmental Disabilities

() Community Home for Persons with Physical Disabilities

Total Number of Residents _____ **Male** () **Female** ()

Provider: PLEASE CHECK IF ITEM IS ENCLOSED WITH THIS APPLICATION OR WRITE IN THE DATE WHEN THE ITEM *HAS BEEN* OR *WILL BE* SENT TO THE DEPARTMENT.

Date or <input checked="" type="checkbox"/> New Applicant		Date or <input checked="" type="checkbox"/>	
<input type="checkbox"/>	Fire Marshal Inspection or date scheduled	<input type="checkbox"/>	Fire Marshal Inspection or date scheduled
<input type="checkbox"/>	Sanitarian Inspection or date scheduled	<input type="checkbox"/>	Sanitarian Inspection or date scheduled
<input type="checkbox"/>	Articles of Incorporation and Bylaws	<input type="checkbox"/>	Major changes to Articles of Incorporation
<input type="checkbox"/>	Organizational Chart	<input type="checkbox"/>	Major Changes to Organization Chart
<input type="checkbox"/>	Job Descriptions for each position	<input type="checkbox"/>	
<input type="checkbox"/>	Personnel and Program Policies	<input type="checkbox"/>	Major changes to Personnel or Program Policies
<input type="checkbox"/>	Board structure and composition with names, addresses and terms of memberships	<input type="checkbox"/>	Board structure and composition with names, addresses and terms of memberships

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PLEASE COMPLETE THE FOLLOWING FOR EACH FULL TIME, PART TIME AND RELIEF STAFF MEMBER

Name	Position	Date of Hire	Med. Cert Date	Orientation Hours	Annual Training Hours	Restraint Training Date	First Aid Training Date

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION GIVEN TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ON THIS APPLICATION IS TRUE AND CORRECT.

Executive Director or Manager

Date